

EC-1	Hawaii Employer-Union Health Benefits Trust Fund ENROLLMENT FORM FOR ACTIVE EMPLOYEES				1. Event:	
					2. Event Date: (MM/DD/YY)	
See Instructions on reverse side BEFORE completing this form. Refer to your reference guide or our website for plan details.						
3a. Employee's Last Name, First, M.I.				3b. Social Security Number:		
3c. Mailing Address:				3g. Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single		3i. Birth Date: (MM/DD/YY)
3d. City:		3e. State:	3f. Zip Code:	3h. Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		3j. Phone Number – Work
4. Social Security Number of Spouse or Domestic Partner <input type="checkbox"/> State or County - Employee or Retiree _____ / _____ / _____ <input type="checkbox"/> Other – Private, Federal ,etc.					3k. Phone Number – Home	
5a. Add	5b. Delete	6a. Dependents: First Name, M.I., Last Name (if different)		6b. Birth Date (MM/DD/YY)	6c. Social Security Number	7. Relationship
<input type="checkbox"/>	<input type="checkbox"/>					8. Gender M <input type="checkbox"/> F <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>					M <input type="checkbox"/> F <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>					M <input type="checkbox"/> F <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>					M <input type="checkbox"/> F <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>					M <input type="checkbox"/> F <input type="checkbox"/>
9. Plan Selections, Changes or Cancellations - Make your selection by checking the box for the appropriate benefit plans below. Select either Self, Family or Cancel/Waive coverage. Choose only one box in each plan section.						
Plan Section		Carrier Selection			Self	Family
Medical/Drug, Chiropractic (choose Self, Family or Cancel/Waive)		HMSA PPO Medical and Drug, MBAH ChiroPlan			<input type="checkbox"/>	<input type="checkbox"/>
		Kaiser Medical and Drug, MBAH ChiroPlan			<input type="checkbox"/>	<input type="checkbox"/>
		HMSA Dual Coverage Medical/Drug, Chiropractic (I have medical/drug coverage from another source outside of EUTF)			<input type="checkbox"/>	<input type="checkbox"/>
		Royal State Dual Coverage Medical/Drug, Chiropractic (I have medical/drug coverage from another source outside of EUTF)			<input type="checkbox"/>	<input type="checkbox"/>
		HMSA Prescription Drug Only (Cannot be combined with any plan listed above)			<input type="checkbox"/>	<input type="checkbox"/>
Dental (choose Self, Family or Cancel/Waive)		HDS Dental			<input type="checkbox"/>	<input type="checkbox"/>
		HDS Dual Coverage Dental (I have dental coverage from another source outside of EUTF)			<input type="checkbox"/>	<input type="checkbox"/>
Vision (choose Self, Family or Cancel/Waive)		VSP Vision			<input type="checkbox"/>	<input type="checkbox"/>
		VSP Dual Coverage Vision (I have vision coverage from another source outside of EUTF)			<input type="checkbox"/>	<input type="checkbox"/>
AETNA Life Insurance Plan					<input type="checkbox"/>	<input type="checkbox"/>
10. State Employees ONLY (Premium Conversion Plan) <input type="checkbox"/> Enroll <input type="checkbox"/> Do NOT Enroll <input type="checkbox"/> Change amount <input type="checkbox"/> Cancel PCP						
11. Comments:						
12. Certification (see instructions on back of this form)						
Employee Signature: _____ Date: _____						
13. DPO Signature: _____		Received Date: _____		DPO Phone: _____		DPO FAX: _____
14. Dept. ID# _____		15a. Dept: _____		15b. Division/ School: _____		16. Barg. Unit: _____



EC-1

SUBMIT TO YOUR PERSONNEL OFFICE

Form EC-1 Revised July 2004

INSTRUCTIONS FOR COMPLETING EC-1 FORM

- A. Print or type clearly, if form is unreadable it may be sent back to you.
- B. **Please submit form to your Personnel Office or Department Personnel Officer (DPO) for verification.**
- C. **This form revised July 2004 is to be used for effective dates beginning July 1, 2004 or later. Do not use this form for events prior to July 1, 2004.**
- D. Sections:
1. Event – DPO, please describe the event. For example, Open Enrollment, Birth, Marriage, Divorce, Loss Coverage, Termination, Transfer In, Transfer Out, Address Chg, Marital Status Chg, Retire, Rehire, New Hire, Death, Student, Add Dep, Cancel etc. If there are simultaneous events, please describe the most prevalent event. For example, if the event is a birth and address change, enter Birth in the event section.
 2. Event Date – DPO, please enter the date the event took place or 7/1/04 for Open Enrollment 2004.
 3. Enter Employee's information for: Last Name, First Name, M.I., Social Security No., Mailing Address, City, State, Zip Code, Marital Status, Gender, Birth Date and Daytime/Evening Phone Number in the appropriate spaces.
 4. Enter Social Security Number of Spouse or Domestic Partner and check appropriate box.
 5. Check add box to add dependent, check delete box to delete dependent.
 6. Enter Employee's Dependent(s) Name, Birth date, and SSN.
If listing more than 5 dependents, write "Continued" on the last line of the Dependent section. Use a separate of paper to list additional dependent(s) information.
 7. Use the following codes for Relationship column:

SP = Spouse	CH = Child	DC = Disabled Child ^{✓✓}
DP = Domestic Partner [✓]	DPC = Domestic Partner Child [✓]	

For Relationship codes with [✓] or ^{✓✓}, please see item #17 below for other required forms.
 8. Gender – check either M or F.
 9. Plan Selections (See Reference Guide for Plan Coverage Details). For Dual Medical plan coverage details see your personnel office or visit the EUTF website. Select only 1 box from each Plan Section.
If you are selecting Medical Dual, Vision Dual or Dental Dual, you must have other coverage from another source outside of EUTF.
 10. PCP – this section is for State employees only. Select Enroll, Do Not Enroll, Change amount, or Cancel. PCP is a voluntary benefit plan, administered by the Department of Human Resources Development (DHRD) that allows employees to purchase their health benefit plans on a pre-tax basis and is being offered pursuant to Section 125 of the Internal Revenue Code. The PCP-2 form is not required for Open Enrollment. For all other qualifying events, please inquire with your DPO or DHRD on completing a PCP-2 form. (See the Reference Guide for Active Employees for details on PCP).
 11. Comments – use this section for your comments
 12. **Certification**
Signature of Employee certifies that the information provided in this application is true and complete. Employee agrees to abide by the terms and conditions of the benefit plans selected. Employee authorizes their employer or finance officer to set the effective dates of coverage and to make the pre-tax or after tax deductions, adjustments or cancellations from employee's salary, wages, pension or other compensation for the monthly employee contribution in accordance with applicable laws, rules and regulations.
Employee affirms that any listed dependent child, aged 19 through 23, is attending a college, university or technical school as a full-time student. Employee affirms that they have non-EUTF plan benefits for each Dual Coverage Plan selected. Employee signature also affirms that they have read and understood the PCP section in the Reference Guide for Active Employees.
Please enter date of Employee's signature.
 13. DPO signature certifies applicant is eligible as defined in Chapter 87A, HRS. Enter date you received EC1 from your employee.
DPO – Please provide your phone and fax numbers.
 14. Department ID code – DPO, please enter your appropriate Department ID code. For example, 010021 for Department of Education, 010022 for University of Hawaii, 040028 for City and County of Honolulu Emergency Services, etc.
 15. Dept: and Division/School: - Optional fields for DPO use only.
 16. Bargaining Unit number – DPO, please enter the appropriate bargaining unit for this employee.
 17. Other EUTF forms to include with EC-1 (if applicable):
 - [✓]Domestic Partnership Declaration or Termination
 - [✓]Domestic Partner PCP Acknowledgement Form (State Employees with PCP enrolling Domestic Partners)
 - [✓]Affidavit of "Dependency" for Tax Purposes (For Domestic Partnerships)
 - ^{✓✓}D-1 (5/2003) for enrolling disabled child
 - AETNA Life Insurance Designation of Beneficiary (If enrolling for the first time or changing beneficiaries)